COCONINO COUNTY HEALTH DEPARTMENT
Making A Difference Every Day

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____Maiden: _____ DOB: _____/____/_____

Address: _____ City: _____ State: _____ Zip: _____

I have registered with the Coconino County Health Department as a person that would need assistance in an evacuation. I authorize and request that a copy of my registration be released as follows:

FROM: Coconino County Health Department

2625 N. King Street/Flagstaff/AZ 86004

Tel (928) 522-7920 / Fax (928) 522-7922

TO: Coconino County Emergency Operations Center and related emergency response personnel
Only to be released if an evacuation is imminent

I understand that this consent is revocable, in writing, at any time prior to the release of this information. This authorization will expire 1 year from the date below. By this acknowledgement, I release Coconino County from all legal responsibility or liability that may arise from release of my registration information.

I further understand that emergencies are unpredictable and that every effort will be made to assist those in need; however my registration as a Special Needs Individual in no way guarantees emergency transportation will be available.

_____ _____
Patient Signature Date

_____ _____
(Or) Legal Guardian/Power of Attorney Date

_____ _____
Witness Date

Please mail the signed Information Release Authorization to:
Coconino County Health Department
Attn: Emergency Preparedness
2625 N. King Street
Flagstaff, AZ 86001